ME-OW

Work Capacity Evaluation
Musculoskeletal Conditions

Print Reset

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

Injured Worker's Name (*First, middle, last*)	OWCP No.	OMB No: 1215-0103 Expires: 08-31-2005

Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions:

1a. Is the worker capable of performing his/her usual job? ☐ Yes ☐ No. If no, please explain.

Many employers can readily accommodate medical restrictions including assignment of the injured worker into an alternative work location.

b. If the claimant is unable to perform his her usual job, is the claimant able to work for 8 hours per workday with restrictions? ☐ Yes ☐ No. If no, please provide medical reasons to support your opinion.

c. If less that 8 hour per workday, how many can he/she work?

d. Do you anticipate an increase in the number of hours this person will be able to work? ☐ Yes ☐ No

e. If yes, when will this person achieve an 8 hour workday? If no, please provide medical reasons to support your opinion

f. How long will the restrictions apply?

g. Has maximum medical improvement been reached? ☐ Yes ☐ No.

2. Please indicate whether this person has any **LIMITATION** in the activity listed and how many hours this person can perform each activity. If there are limitations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.

Activity	Limitation	# of Hours Able to Work
Sitting	☐ Yes	
Walking	☐ Yes	
Standing	☐ Yes	
Reaching	☐ Yes	
Reaching above Shoulder	☐ Yes	
Twisting	☐ Yes	
Bending/Stooping	☐ Yes	
Operating Motor Vehicle at work	☐ Yes	
Operating a Motor Vehicle to/from work	☐ Yes	

Activity	Limitation	# of Hours Able to Work	Lbs.
Repetitive Movements:			
Wrists	☐ Yes		
Elbow	☐ Yes		
Pushing	☐ Yes		
Pulling	☐ Yes		
Lifting	☐ Yes		
Squatting	☐ Yes		
Kneeling	☐ Yes		
Climbing	☐ Yes		
Breaks:			
Duration		Frequency	
Duration		Frequency	

3. Are there **OTHER** medical facts, situational factors, equipment or devices which need to be considered in the identification of a position for this person? If so, please explain.

4. Physician's Name (First, middle, last) (*Type or print*)	5. Telephone
6. Signature	7. Date

The information requested will assist OWCP in determining eligibility to benefits and is required to obtain or retain a benefit. (5 USC 8101 et. seq.)

Public Burden Statement

We estimate that it will take an average of 15 minutes per response to complete this information collection including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.